INDEPENDENT REVIEW INCORPORATED

Notice of Independent Review Decision

REVIEWER'S REPORT

Date notice sent to all parties: 09/14/12

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Functional restoration program 5 X 2 visits (97799)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D., board certified in General Psychiatry and Child and Adolescent Psychiatry

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

	Upheld	(Agree)
X	**Overturned**	**(Disagree)**
	Partially Overturned	(Agree in part/Disagree in part)

Primary Diagnosis Code	***Service Being Denied***	***Billing Modifier***	***Type of Review***	***Units***	***Date(s) of Service***	***Amount Billed***	***Date of Injury***	***DWC Claim #***	***Upheld Overturn***
724.02	***97799***		***Prosp.***						***Overturn***

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. Certification of independence of the reviewer.
2. TDI case assignment.
3. Letters of denial 07/19/12 & 08/24/12, including review summary and criteria used in the denial.
4. Orthopedic H&P and evaluation 08/02/12.
5. Response to denial letter 07/27/12.
6. Functional Capacity Evaluation 07/13/12
7. Treatment progress report 07/12/12.
8. Rapid Assessment of Drug Adherence Report 04/08/12.

PATIENT CLINICAL HISTORY [SUMMARY]:
The worker is a male who suffered a work-related lumbar spine injury on xx/xx/xx. He underwent surgical decompression with stabilization of L3/L4 and L4/L5 in April 2011. He received post-operative rehabilitation including aquatic therapy. He has received time off from work, counseling, and no longer uses his back brace. FCE completed on 07/13/12, indicates he is no longer qualified for his pre-injury job. He intends to return to the work force in some capacity. He will require assistance in formulating a plan for return to work. Patient has completed five (5) days (40 hours) of program intervention within the timeframe given by the carrier. The request has been made this his functional restoration program be continued for an additional five (5) sessions. Areas that still need improvement are to help negative cognition and perception of disability, and to increase his ability to obtain employment that fits within his physical demand level. These areas will include reinforcing coping capacities to manage rehabilitation demands with decreased medicine and meeting job goal of physical demands for activities of daily living.

The request has been denied. Among the concerns stated in the initial letter of denial and summary, there had been no urine drug screen to document medication compliance and possible illicit drug use. Following the initial denial, a rapid urine drug screen was completed, which was referenced in the 2nd letter of denial. The 2nd letter of denial referenced the fact that diagnostic studies were pending or being ordered, and it was possible that some additional treatment could result in clinical improvement pending the results of the diagnostic studies.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
Although the outcome of pending studies could influence further treatment, there is nothing about the pending outcomes that would preclude continued participation in the functional restoration program. The number of sessions used to date, as well as those requested fall well within the ODG Guidelines as referenced in the response to denial.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
☐ AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ INTERQUAL CRITERIA

X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)